LOCAL GOVERNMENT ANNUITANT OR CONTINUANT ONLY

Instructions:

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

GROUP: **LOCAL GOVERNMENT ANNUITANT OR CONTINUANT** **DUAL-CHOICE** HEALTH INSURANCE APPLICATION

Applicant – Last Name	First	Middle I.	Social Security Number

Address – Street & No.	City	State	ZIP Code	County	Home Telephone Number Area/No.

Marital Status ☐ Single ☐ Married Date_____ ☐ Divorced Date_____ ☐ Separated Date_____ ☐ Widowed Date_____

Spouse's/Ex-Spouse's Name & Social Security Number

CURRENT GROUP HEALTH INSURANCE PLAN

Plan Name _____

Group No. _____

NEW GROUP HEALTH INSURANCE PLAN SELECTED

Plan Name _____
(list complete name, including location if part of name)

COVERAGE DESIRED

☐ Single ☐ Family

OTHER HEALTH INSURANCE COVERAGE (*You must complete this section*)

Are you or a family member insured under Medicare? ☐ No ☐ Yes

If yes, list names of insured and Medicare effective dates.

Name: _____ Dates: Part A _____ Part B _____

Name (spouse):_____ Dates: Part A _____ Part B _____

Are you or a family member insured under another health insurance plan? ☐ No ☐ Yes

If yes, list names of insured and plan.

Name: _____

Name (Spouse): _____

Plan Name (Insurance Co.): _____

Group No.: _____ Subscriber (Policy) No.: _____ Name of Employer:_____

Last Name First Middle I.	Birthdate MO	DAY	YR	Sex M/F	Social Security Number	Appl. Rel. Code (see page H-2)	**YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN, COUNTY** in which located, and **PROVIDER NUMBER** (if available). Indicate **NONE** if electing the Standard Plan. PHYSICIAN NAME	PROVIDER/ PHYSICIAN COUNTY	PROVIDER NUMBER	CARRIER USE / PRS Code
Applicant						N/A				
Spouse						N/A				
Eligible Dependent(s)										

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

☐ I am a retiree or surviving spouse/dependent
☐ I am on continuation (eligible for a maximum of 36 months' coverage)

DATE SIGNED (MM/DD/CCYY)

APPLICANT SIGNATURE

SIGN HERE

Return completed form to:

EMPLOYEE TRUST FUNDS
P.O. Box 7931
Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2002**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY

ENROLLMENT TYPE	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
40					

EIN	Group Number	ETF Contact Person	Telephone
0000-001	77		(608)

Monthly Premium	Date Received	COBRA Coverage Expires	Effective Date
$			01/01/2002

FOR CARRIER USE	SN	FN	PL	ED	Premium Source 01 02 03 04

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
2. I agree to pay the current premium for this insurance.
3. I agree that any physician, hospital, or other institution who attends or has attended me, my spouse, or any of my children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis. I authorize ETF to obtain all necessary information from the insurance carrier.
4. Any children listed on this application are unmarried and dependent on me, or the other parent, for support and maintenance. If over the age of 19, they are a full-time student; if over the age of 25, they are disabled of long standing duration and are incapable of self-support.
5. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.